CHAPTER II

PROVIDER PARTICIPATION REQUIREMENTS

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PARTICIPATING CASE MANAGEMENT PROVIDER

A participating case management provider is an institution, facility, agency, person, partnership, corporation, or association that meets the standards and requirements set forth by DMAS and has a current, signed contract with DMAS. A copy of the Case Management Provider Contract is included as Exhibit II.1.

CASE MANAGEMENT AGENCIES

Case management agencies provide services designed to prevent or reduce inappropriate institutional care by providing the continuous assessment, coordination, and monitoring of needs and services for Medicaid-eligible HIV-infected individuals who have been preauthorized for waiver services. To be authorized for AIDS waiver services, the individual must be diagnosed with either AIDS or ARC (the term used by DMAS to apply to those individuals with HIV infection experiencing symptoms related to the infection), requiring either a hospital or nursing facility level of care. (Appendix C contains these criteria.) The following provisions govern providers of case management services.

REQUESTS FOR PARTICIPATION

Requests for applications for case management provider participation must be addressed to:

Manager, Community-Based Care
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Requests will be screened to determine whether the applicant meets the basic requirements for participation (i.e., prior experience in the delivery of health care coordination service for individuals with AIDS/ARC).

An application for case management provider status and information regarding the provider participation requirements and standards will be mailed to any interested party who requests information/application to become a Medicaid-approved provider for case management and who meets the basic requirements for participation. A copy of this application is included in Exhibit II.2. Upon the receipt of a completed application, a DMAS utilization review analyst will be assigned to conduct an on-site visit with the provider. During this visit, the analyst will review provider participation requirements and standards and obtain the required verification and documentation from the provider.

Upon DMAS receipt, review, and determination that the provider meets all the requirements for Medicaid case management provider participation, DMAS will send the provider two copies of the contract for review and signature. Both contract copies must have the original signature of the provider or person authorized to bind the provider under contract. (See Exhibit II.1 in this chapter.)

PROVIDER IDENTIFICATION NUMBER

Upon the receipt of both copies of the signed contract, and the approval and signature by DMAS, a provider identification number will be assigned. The provider will be sent a copy of the contract and the assigned provider identification number. **DMAS will not reimburse the provider for any case management services rendered prior to the assignment of this provider identification number and the receipt of this number by the provider.** This number must be used on all billing invoices and correspondence submitted to DMAS.

PROVIDER PARTICIPATION STANDARDS

To be approved for case management contracts with DMAS, the following must be met:

- Staffing requirements
- Demonstrated prior successful delivery of health care coordination type services
- Financial solvency
- Business office
- Disclosure of ownership
- Assurance of the comparability of services

REVIEW OF PROVIDER PARTICIPATION AND RENEWAL OF CONTRACTS

Case management providers are continually assessed to assure conformance with Medicaid participation standards and program policies. The provider is assessed on its ability to render consistent, continuous monitoring of the service delivery, re-evaluation of the need, and the coordination of services to a population of individuals with AIDS/ARC who would otherwise require inpatient hospital or nursing facility level of care. Information used by DMAS to make this assessment includes DMAS desk review of documentation submitted by the provider as well as on-site review of provider files and visits to recipient's homes. The DMAS assessment of the provider is based on a comprehensive evaluation of the provider's overall performance in the following areas:

- Assessment of Individual Need and Plan of Care Development: The case manager assigned to an AIDS/ARC waiver recipient is responsible for continually assessing the need and for making the necessary revisions to the plan of care to assure the recipient's health and safety. The original pre-admission screening committee plan of care must be submitted to DMAS for prior authorization of waiver services (personal care, respite care, skilled nursing, or nutritional supplements). Thereafter, the case manager has the responsibility to authorize continued services and any changes to the amount or type of services provided. Waiver recipients must continue to meet the criteria for waiver services (either hospital or nursing facility level of care) during any period in which waiver services are authorized, and the plan of care must accurately reflect the recipient's needs and correlate to the services rendered to that recipient.

- Adherence to Plan of Care: It is the case management provider's responsibility to monitor the provision of services according to the amount and type authorized on the plan of care. The case management provider must monitor to assure that a plan of care that calls for personal care services, for example, to be rendered on a seven-day a week basis is staffed on that basis. Any deviation from the plan of care must be evaluated by the case manager and documented in the recipient's file.

- Monthly Logs and Progress Reports: The documentation maintained by the case manager must accurately summarize the contacts between the case manager (and any volunteers utilized by the case management agency) and the recipient. This documentation must reflect a quarterly re-evaluation of the recipient's need for services and adequacy of services rendered as well as ongoing monitoring of the recipient's assessed needs and the service delivery system coordinated for that recipient. The case manager's documentation must also serve as an audit trail of case management activity reimbursed by DMAS for waiver recipients.

- Quality of Care: The case manager must evaluate the recipient's quality of care as reported by the recipient or family and/or observed by the case manager and/or DMAS staff during home visits.

- Billing: Case management services must be documented and match the claims submitted to DMAS by the provider.

- Case Management Visits: The case manager is responsible for adhering to DMAS regulations regarding the frequency and type of communication with waiver recipients.

DMAS will review the provider's performance in all of the above areas to determine the provider's ability to achieve a high quality of care and to conform to DMAS policies. The purpose of this provider review is to provide feedback to the provider regarding those areas which may need improvement. All providers will receive periodic on-site reviews on at least a quarterly basis during their first year of Medicaid provider participation. During these on-site reviews, the analyst will review recipient files and conduct home visits to assess the quality of care and the continued appropriateness of waiver services.

At the end of the provider's first year of service provision, the analyst will review the overall degree of conformance to DMAS policies. Any provider whose compliance is below average may receive a corrective action request to correct the areas in which improvement is needed.

Contracts are reviewed and renewed by DMAS every two years. DMAS utilization review analysts are assigned to each case management provider agency for the purposes of the review of provider participation standards and ongoing recipient utilization review.

GENERAL REQUIREMENTS

Providers approved for participation in the Medical Assistance Program must perform the following activities as well as any other specified by DMAS:

- Immediately notify DMAS, in writing, of any change in the information which the provider previously submitted to DMAS. This includes any change in provider status (address, staff, etc.) as well as any change in a recipient's condition or level of service delivery.
- Assure freedom of choice to recipients in seeking medical care from any institution, pharmacy, practitioner, or other provider qualified to perform the service(s) required and participating in the Medicaid Program at the time the service was performed.
- Assure the recipient's freedom to reject medical care and treatment.
- Accept referrals for services only when staff is available to initiate services.
- Provide services and supplies to recipients in full compliance with Title VI of the Civil Rights Act of 1964 which prohibits discrimination on the grounds of race, color, creed, age, or national origin.

- Provide services and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973 requiring that all necessary accommodations be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, and disabilities of coordination (refer to the section in this chapter entitled Requirements of Section 504 of the Rehabilitation Act).

- Provide services and supplies to recipients in the same quality and mode of delivery as provided to the general public.

- Charge DMAS for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges to the general public.

- Accept Medicaid payment from the first day of eligibility.

- Accept as payment in full the amount established by the Department of Medical Assistance Services. 42 CFR, Section 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the State. A provider may not seek to collect from a Medicaid recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established Medicaid allowance for the service rendered.

  If a third party payer reimburses $5 out of an $8 charge, and Medicaid's allowance is $5, then payment in full of the Medicaid allowance has been made. The provider may not attempt to collect the $3 difference from Medicaid, the recipient, a spouse, or a responsible relative.

- Use Program-designated billing forms for the submission of charges.

- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Such records shall be maintained in a designated business office from which all case management provider agency business is conducted.

  Such records must be retained for a period of not less than five years from the last date of service or as provided by applicable state laws, whichever period is longer, except that, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. Records of minors must be kept for at least five (5) years after such minor has reached the age of 18 years.

Policies regarding the retention of records shall apply even if the agency discontinues operation. DMAS must be notified in writing of the storage, location, and procedures for obtaining records for review should the need arise. The location, agent, or trustee should be within the Commonwealth of Virginia.

- Furnish to authorized State and federal personnel, in the form and manner requested, access to records and facilities.

- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of Medicaid.

- Hold confidential and use for authorized DMAS purposes only all medical assistance information regarding recipients. A provider shall disclose information in his possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. The state agency shall not disclose medical information to the public.

- Employ and supervise professionally-trained staff (meeting the requirements stated in this chapter) to provide case management services.

- Assure that no processing of bankruptcy or financial insolvency has been adjudicated or is pending in State or Federal Court and agree to inform DMAS of any action instituted with respect to financial solvency.

- Have consistently operated as a care coordination provider prior to application for Medicaid case management provider status.

ADHERENCE TO PROVIDER CONTRACT AND SPECIAL PARTICIPATION CONDITIONS

In addition to the above, all providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their individual provider contract. The paragraphs which follow outline special participation conditions which must be agreed to by case management providers.

Recipient Choice of Provider Agencies

If case management services are authorized and there is more than one approved provider agency in the community, the individual will have the option of selecting the provider agency of his or her choice.

Case Manager Requirements

The provider agency must employ and **directly supervise** an individual or individuals who will provide ongoing monitoring, re-evaluation, and coordination of services for all AIDS waiver recipients provided case management through the agency. The case manager(s) must possess, at a minimum, a baccalaureate degree in human services (i.e., social work, psychology, sociology, counseling, or a related field) or nursing and the appropriate knowledge, skills and ability to perform case management for this population:

- Knowledge of the infectious disease process (specifically HIV) and the needs of the terminally-ill population, and knowledge of the community service network and eligibility requirements and application procedures for applicable assistance programs;

- Ability to access other health and social work professionals in the community to serve as members of a multi-disciplinary team for the re-evaluation and coordination of services activities, ability to organize and monitor an integrated service plan for individuals with multiple problems and limited resources, ability to access (or have expertise in) medical and clinical expertise related to HIV infection, and ability to demonstrate liaisons with clinical facilities providing diagnostic evaluation and/or treatment for persons with HIV; and

- Skills in communication, service plan development, client advocacy, and the monitoring of a continuum of managed care.

Documentation of all staffs' credentials shall be maintained in the provider agency's personnel file for review by DMAS staff. Providers of case management may utilize the services of volunteers or employees who do not meet this criteria to perform the day-to-day interactions with recipients commonly included in the case management process. There must be, however, a case manager responsible for the supervision of these volunteers or employees, of the decision-making related to the individual's plan of care and the appropriateness for waiver services, and for the training of the volunteers or employees interacting with the waiver recipient.

The case manager must have contact with the waiver recipient, at a minimum, once every 30 days. If the waiver recipient has a volunteer(s) or other staff assigned for regular face-to face contact, this contact by the case manager may be a telephone contact. Otherwise, the contact by the case manager must be a face-to-face interaction.

The case manager must have contact with the providers of direct waiver service(s), at a minimum, once every 30 days. Collateral contacts with other supports should be made periodically, as determined by the needs of the recipient and the extent of the support system.

The case manager's caseload should not exceed 25 waiver recipients. This caseload size is deemed desirable for optimum monitoring and re-evaluation ability. However, it is recognized that the abilities of the case manager to manage a caseload will depend on many variables (i.e., other duties, the availability of resources, the stage of disease process for the recipients in the caseload, etc). Therefore, the caseload size is recommended and can be exceeded as long as the quality of case management services is not affected.

Any agency which meets DMAS requirements may contract with DMAS to provide case management services. Any agency applying to be a case management provider which also renders any of the direct waiver services (private duty nursing, personal care, or respite care) must be able to clearly demonstrate that case management services will be provided by staff which have no participation in the delivery of direct services and that recipient freedom of choice and the ability to objectively monitor service delivery can be maintained.

Case Management Volunteers

Providers of case management may utilize the services of volunteers or employees other than the case manager to perform the day-to-day interactions with recipients commonly included in the case management process. Case management functions may be performed by an individual other than the case manager when the following conditions are met:

- The individual has received specialized training in the needs of the AIDS/ARC individual, the individual's plan of care and community resources, and generalized training in communication skills, client advocacy, and monitoring the direct service provision;
- The individual will be supervised by a case manager;
- The case manager will have case consultations at least once a week with the individual who is making the direct contact;
- All decisions regarding waiver service delivery must be made by the case manager and cannot be delegated to an individual supervised by the case manager; and
- The case manager at a minimum maintains telephone contact with the AIDS waiver recipient on at least a monthly basis.

Continuity of Service Provision

The case management provider is responsible for providing the reliable, continuous monitoring and coordination of services to any Medicaid case management recipient. Any time the provider is unable to render care to a recipient, the recipient must be notified and given the choice of transfer to another case management provider.

Documentation Required - Client Record

The case management provider agency shall maintain all records of each case management client. These records shall be reviewed periodically by DMAS staff. The case manager is responsible for maintaining a file for each recipient which includes:

- The recipient's pre-admission screening assessment documentation (Consent for Release of Information, DMAS-20; Pre-Admission Screening Assessment Instrument, DMAS-95; the MI/MR Supplement, DMAS-95 MI/MR; the Nursing Home Pre-Admission Screening Authorization, DMAS-96; the Medicaid HIV Services Pre-Screening and Plan of Care, DMAS-113A and DMAS-113B) Appendix B contains samples of these forms.

- All subsequent revisions to the Medicaid HIV Services Plan of Care (DMAS-113B), all DMAS-122s, and communications from DMAS, physician, service providers, etc. (See Appendix B for samples of these forms.)

- A monthly log which lists the dates and duration of all contacts between case management provider staff and the recipient and summarizes the nature of those contacts. This log is not a DMAS form and may be maintained is any format chosen by the case manager as long as all data required by DMAS are included. The log must be maintained by the case manager and any volunteer or employee supervised by the case manager who is routinely assigned to interact with the waiver recipient. If the recipient has a volunteer and case manager who interact with the recipient during the month, two logs could be maintained by the different parties; but both must be placed in the recipient's file by no later than the fifth day of the month following the contact month.

- A 30-day recipient progress report maintained by the case manager which summarizes on a monthly basis the recipient's status (e.g., any change in the recipient's medical status, service needs, social support, and the hospitalization admission and discharge dates), the reason for any changes to the plan of care and which documents all communications between the case manager and other service providers, family, physicians, DMAS, and all professionals concerning the client. This progress report must also document the quarterly re-evaluation of the recipient's need for continued service and the appropriateness of the care provided. The report is not a DMAS form and may be maintained in any format chosen by the case manager as long as all data required by DMAS are included.

- All updated DMAS-95s, direct service provider agency plans of care, and DMAS utilization review forms. (See Appendix B for a sample of this form.)

The case manager is responsible for the review and revision, if necessary, of the plan of care no less often than every three months. This review must be documented in the recipient's file. The documentation must note all members of the case management team who provided input to the plan of care. (See Chapter IV for a description of the plan of care process.)

Change of Ownership

When ownership of the provider agency changes, DMAS must be notified within 15 calendar days. A new contract, notice of the organizational structure, statements of financial solvency and service comparability, and a full disclosure of all information required by this chapter relating to ownership and interest will be required.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 provides that no handicapped individual shall, solely by reason of the handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. As a condition of participation, each Medicaid provider has the responsibility for making provision for handicapped individuals in their program activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. A compliance notice is printed on the claim form completed by providers. The provider indicates compliance with Section 504 of the Rehabilitation Act upon submission of the claim for Medicaid reimbursement.

In the event a discrimination complaint is lodged, DMAS is required to provide the Office of Civil Rights (OCR) with any evidence regarding compliance with these requirements.

PROVIDER SANCTIONS (Adverse Actions)

Sanctions are any adverse action taken by DMAS based on documented non-compliance by the provider. There are three categories of sanctions imposed by the Department of Medical Assistance Services: reimbursement sanctions, caseload sanctions, and contract sanctions. The following describes these sanctions and the manner in which they are applied:

1. Provider Reimbursement Sanctions – A reimbursement sanction is any disallowed claim for Medicaid services due to the service being rendered in a manner which is not in accordance with DMAS policies and procedures. Reimbursement sanctions are of two types: recipient-specific and provider-specific. The distinctions are important in relation to how the sanction is applied.

- A recipient-specific sanction is a disallowance of payment for a claim for which the DMAS analyst is either unable to verify that the service was rendered or that the service was rendered in a manner which is not authorized by the plan of care or according to DMAS policies. The following are examples of situations that will give rise to recipient-specific reimbursement sanctions:

  - Missing documentation for case management services as required by DMAS policies;

  - Inadequate monthly logs which do not document the amount of service rendered consistent with the amount billed DMAS;

  - Plan of care authorizes an excessive amount of services in relation to the recipient's documented need;

  - Recipient does not meet the level of care for waiver services but has not been terminated to direct services (personal care, respite care, or skilled nursing).

- A provider-specific reimbursement sanction is the disallowance of claims for more than one recipient based on the provider's failure to adhere to provider participation standards (e.g., staff qualification requirements and case manager contact requirements) which directly affect service delivery to recipients. The following are examples of situations that will give rise to provider specific reimbursement sanctions:

  - The provider fails to employ a case manager to provide contacts to recipients during one month affecting five recipients who are not contacted by a case manager within the 30-day period required by DMAS policy. Claims for case management for that month will be disallowed for all five recipients.

  - A review of provider personnel files shows that the case manager employed by the provider does not meet DMAS requirements. Claims for days of service for any recipient for whom services were rendered by this case manager will be disallowed.

Provider non-compliance will be cited as a deficiency in the post-review letter to the provider, and a warning will be given that DMAS will impose a sanction if the non-compliance re-occurs or continues. The analyst will discuss his or her finding with the provider and in the post-review letter state why this determination was made and provide instructions to the provider for the correction of the plan of care.

A reimbursement sanction will be imposed if the analyst had previously documented such non-compliance.

2. Caseload Sanctions - These sanctions are applied to protect the health and safety of recipients when a provider is not in compliance with provider participation standards, and therefore, is not able to provide adequate community-based care (CBC) coverage. Caseload sanctions include:

   a) A freeze on all new admissions and

   b) The transfer of recipients to other case management providers.

   A request for a corrective action plan to be reviewed and approved by DMAS will be initiated whenever a caseload sanction is imposed.

3. Contract Sanctions - These sanctions are applied when a provider demonstrates an inability to comply with either provider participation standards or program policies, and therefore, presents a risk to the quality of care of CBC recipients or an immediate risk to their health and safety which cannot be corrected. Contract sanctions include:

   a) Time-limited contract - The provider is attempting to correct the non-compliance but has not made sufficient progress to warrant a full two-year contract. A contract may be issued for a period not less than one month and not greater than one year. A corrective action request must be initiated whenever a time-limited contract sanction is imposed.

   b) Contract not renewed - The provider's contract may be due for renewal, and progress has not been sufficient to allow renewal of the contract on even a limited basis.

   c) Contract termination - The provider has been unable to correct the non-compliance and presents an immediate risk to recipients of CBC service.

PROVIDER CORRECTIVE ACTION

A provider's non-compliance with DMAS policies and procedures may result in a written request from DMAS for a corrective action plan which details the steps the provider will take and the length of time required to achieve full compliance with deficiencies which have been cited. The decision to request corrective action will be based on the type of non-compliance and its affect on the overall quality of care, whether a pattern of non-compliance exists, whether the non-compliance presents a threat to the health and safety of recipients, and the circumstances that may have created the non-compliance.

For example, a provider's failure to follow policies due to a sudden staff turnover may not represent a pattern of non-compliance or present an immediate threat to the health and safety of recipients, and thus, a corrective action may not be necessary.

DMAS will identify and document non-compliance issues to the provider and will offer technical assistance to correct the non-compliance. A request for corrective action will be issued when the non-compliance continues after having been addressed with the provider by DMAS (except in those instances where the risk of immediate danger to recipients requires immediate improvement). A corrective action may include a caseload or contract sanction.

The provider shall respond with a written corrective action plan within 10 working days of the DMAS request. 'DMAS will review the plan and respond to the provider within 15 days of receipt of the plan regarding the acceptability of the plan. DMAS will closely monitor the provider's progress and provide a written corrective action progress report at the end of the first quarter in which the plan takes place. At the end of a six-month period, a provider may be removed from corrective action status if DMAS finds that correction has been achieved. Failure either to respond to a request for corrective action or to adhere to the approved corrective action plan may result in contract revocation according to the termination procedures described later in this chapter.

TERMINATION OF PROVIDER PARTICIPATION

A participating provider may terminate his participation in Medicaid at any time. Sixty (60) days' written notification of voluntary termination must be made to the following:

Manager, Community-Based Care
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

DMAS may administratively terminate a provider from participation upon 60 days' written notification. DMAS may also cancel a contract immediately or may give notification in the event of a breach of the contract by the provider as specified in Article VII of the contract. Such action precludes further payment by DMAS for services provided clients subsequent to a date specified in the termination notice.

RECONSIDERATION OF ADVERSE ACTIONS

The following procedures will be available to all providers when DMAS takes adverse action which includes the termination or suspension of the provider agreement.

The reconsideration process will consist of three phases: a written response and reconsideration to the preliminary findings, the informal conference, and the formal evidentiary hearing. The provider will have 30 days from the date of the notice to submit information for written reconsideration, will have 15 days to request the informal conference, and will have 15 days to request the formal evidentiary hearing.

An appeal of adverse actions concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (Section 9-6.14:1 et seq.) and the State Plan for Medical Assistance provided for in Section 32.1-325 of the Code of Virginia. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act.

Any legal representative of a provider must be duly licensed to practice in the Commonwealth of Virginia.

TERMINATION OF A PROVIDER CONTRACT UPON CONVICTION OF A FELONY

The Code of Virginia, Chapter 10, Department of Medical Assistance Services, Section 32.1-325(c), mandates that "Any such (Medicaid) agreement or contract shall terminate upon conviction of the provider of a felony."

A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 days, notify the Program of this conviction and relinquish the agreement. Reinstatement will be contingent upon the provisions of State law.

EXHIBIT II.1

CONTRACT

The Contract, made the ____ day of _____, 19__, by and between the Department of Medical Assistance Services of the Commonwealth of Virginia (hereafter referred to as "Department"), and _____ (hereafter referred to as "Contractor").

WITNESSETH:

That for and in consideration of the respective undertakings of the parties of this contract, the "Department" and the "Contractor" hereby covenant and agree, each with the other, as follows:

ARTICLE I – PURPOSE AND SCOPE OF SERVICE

The Contractor shall provide such services through the assignments of Case Managers to eligible individuals for the provision of Case Management services. Accordingly, the undersigned, representing the Department and the Contractor, agree that the following duties and responsibilities will be provided by the Contractor and the Department.

(1) Services will be provided without regard to race, color, religion, or national origin. No handicapped individual shall, solely by reason of his handicap, be excluded from participation, be denied benefits, or be subjected to discrimination (Section 504 of the Rehabilitation Act of 1973, 29 USC.706).

(2) The Contractor agrees to keep such records as the Department determines necessary. The Contractor will furnish the Department on request information regarding payments claimed for providing services under the AIDS/ARC Waiver or State Plan. Access to records and facilities by authorized Department representatives, the Attorney General of Virginia or his authorized representatives, and authorized federal personnel will be permitted upon reasonable request.

(3) The Contractor agrees to abide by the rules, policies, and procedures of the State Plan for Medical Assistance as stated in the Case Management Provider Manual, Department memoranda, and other applicable State and Federal laws and regulations and will perform these required services in accordance with any changes in said policies and procedures upon receipt by the Case Management agency of written notice of said changes and alterations.

ARTICLE II – TIME OF PERFORMANCE

The services of the Contractor shall commence on _____ and shall terminate on _____, the period of performance being 24 months.

ARTICLE III – COMPENSATION

(1) The Contractor agrees to care for individuals at the current fixed rate as determined by the Department, total payment to the Contractor not to exceed the Department's ceilings, and shall submit requests for payment in accordance with the Department's policies.

(2) The Department will reimburse the Contractor only for covered services for those patients who are eligible recipients of Medical Assistance in Virginia and affected by illness or disability requiring Case Management services as attested by a physician and in accordance with the Department's policies.

(3) Payment by the Department for covered services shall constitute full and complete settlement of a patient's account. The Contractor shall not request additional payments for services provided under this contract from other sources.

(4) Upon receipt of properly and timely submitted requests for payments for services provided, the Department shall promptly and expeditiously make payments to the Contractor.

Note: Advance payment cannot be made to third party non- governmental contractors except in accordance with the State Comptroller regulations and provisions of the State Code.

ARTICLE IV – GENERAL PROVISIONS

Nothing in this agreement shall be construed as authority for either party to make commitments which will bind the other party beyond the Scope of Service contained herein. Furthermore, the Contractor shall not assign, sublet, or subcontract any work related to this agreement or any interest he/it may have herein without the prior written consent of the Department. This contract is subject to appropriations by the Virginia General Assembly.

ARTICLE V – LIABILITY

The Contractor shall indemnify and hold harmless the Department and the Commonwealth of Virginia, and when applicable, its employees and designated representatives, from any and all claims, suits, actions, liabilities, and costs of any kind caused by the performance by the Contractor of his/its work pursuant to this agreement. Nothing contained herein shall be deemed an express or implied waiver of the immunity of the Commonwealth. The Contractor shall provide such malpractice and/or liability insurance as may be necessary to protect him/it from claims for damages which may arise under this contract.

ARTICLE VI – LAWS, PERMITS, AND RESTRICTIONS

This agreement shall be governed in all respects, whether as to validity, construction, capacity, performance or otherwise, by the laws of the Commonwealth of Virginia.

ARTICLE VII – TERMINATION

(1) This contract may be cancelled by either party by giving sixty (60) days written notice to the other, or

(2) This contract shall be cancelled automatically in the event the State, or Federal government fails to appropriate or allocate sufficient funds for the purpose of continuation of this agreement, or

(3) In the event the Contractor breaches this agreement, the Department may do the following:

a) If the Department determines that said breach constitutes a potential/actual health and/or safety risk to individuals eligible for Case Management, the Department shall have the right to immediately rescind, revoke, or terminate the agreement. In the event the Department, at its sole discretion, allows the Contractor a limited time period to correct potential/actual health and/or safety breaches, said action shall not constitute a waiver by the Department of its right to immediately rescind, revoke or terminate the agreement for subsequent breaches and/or failure to correct in a timely manner.

b) In the alternative, if the Contractor breaches and the Department determines that the breach does not pose a potential/actual health and/or safety risk, the Department shall have the right to give written notice to the Contractor specifying the manner in which the agreement has been breached, allowing a thirty (30) day period in which to correct the breach. If the Contractor has not substantially corrected the breach within the thirty (30) days, the Department shall have the right to immediately rescind, revoke, or terminate the agreement.

ARTICLE VIII – APPEALS OF ADMINISTRATIVE ACTIONS

All disputes regarding provider reimbursement and/or termination of this agreement by the Department for any reason shall be resolved through administrative proceedings conducted at the office of the Department in Richmond, Virginia. Judicial review of such administrative actions shall be pursuant to the Administrative Process Act.

ARTICLE IX – INTEGRATION AND MODIFICATION

This agreement constitutes the entire agreement between the Contractor and the Department. No alteration, amendment, or modification in the provisions of this agreement shall be effective unless it is reduced to writing, signed by the parties, and attached hereto.

ARTICLE X – CONFLICT OF INTEREST

The Contractor warrants and certifies that the execution and performance of this agreement does not and will not violate the Virginia Comprehensive Conflict of Interests Act.

ARTICLE XI – NONDISCRIMINATION

In his/its performance of this agreement, the Contractor warrants that he/it will not discriminate against any employee, or other person, on account of race, color, sex, religious creed, ancestry, age, or national origin. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

The Contractor shall, in all solicitations or advertisement for employees placed by or on behalf of the Contractor, state that such Contractor is an equal opportunity employer; provided, however, that notices, advertisements, and solicitations placed in accordance with Federal law, rules, or regulations shall be deemed sufficient for the purpose of meeting the requirements of this contract.

The Contractor shall include the provisions of the foregoing paragraphs in every subcontract or purchase order of over $10,000, so that such provisions will be binding upon each subcontractor or vendor.

In witness thereof, the "Department" and the "Contractor" have caused this contract to be executed by their officials thereunto duly authorized.

DO NOT USE:
Department of Medical Assistance Services

by: _____ _____
Director, Division of Client Services
Title

Provider of Services

by: _____ _____
Signature of Provider Date

_____
Title

___ City or ___ County of _____

_____ _____
IRS Identification Number Social Security No.

(_____) _____
Area Code Telephone No.

This contract is approved as to form by the Office of the Attorney General.

EXHIBIT II.2

HOME AND COMMUNITY-BASED CARE PROVIDER ENROLLMENT APPLICATION

Case Management Services

In accordance with the provisions of 42 CFR 441.302 (a) (1) all providers of Home and Community-Based Care Waiver services must submit the following information to the Department of Medical Assistance Services.

Any changes which affect the accuracy of the following information must be reported promptly to the Community-Based Care Section of the Department of Medical Assistance Services.

Application requested for: (Check One)

Initial Enrollment of Provider (Entire application must be completed.) _____

Changes in Ownership or Operation (items 1-14, 21, and 22 must be completed) _____

A. GENERAL INFORMATION:

1. _____ Official Name of Agency

2. _____ Street Address

3. _____ City/Town _____ State _____ Zip Code

4. _____ County

5. Official Mailing Address (if different from above):

_____

_____

6. Chief Administrative Agent (person responsible for administrative functions of the agency: signing contracts, receiving and acting on utilization review findings, etc.):

_____ Name _____ Title _____ Phone #

7. Other Contact Person:

_____ Name _____ Title _____ Phone #

8. Is this agency licensed by any other governmental agency?
___yes ___no

Describe License: _____ License #: ___

B. OWNERSHIP:

9. Legal name(s), address(es) and percent of ownership.
(Attach additional page if necessary.)

_____ _____

_____ _____

_____ _____

9a. Pursuant to 42 CFR 455, any person listed in #10 with 5 percent or more ownership of any other Medicaid provider agency or agency that participates in any of the programs established under Title V, XVIII, or XX of Social Security Act must disclose such ownership. List the name of any such agency and the person with ownership.

_____

_____

10. Is the provider agency applicant operated by its owner?
___yes ___no
If the agency is owner-operated, complete Column A below.
If the agency is not operated by the owner, complete Column A and Column B.

A OWNER (one)	B OPERATOR (one)	C TYPE OF AGENCY (any that apply)
		State or Local Government
_____	_____	_____ State
_____	_____	_____ County/City
_____	_____	_____ Hospital
		Non-Profit
_____	_____	_____ Church Related
_____	_____	_____ Non-Profit Corporation
_____	_____	_____ Other Non-Profit
		Proprietary
_____	_____	_____ Single Proprietorship
_____	_____	_____ Partnership
_____	_____	_____ Corporation
_____	_____	_____ Hospital/Nursing Home
_____	_____	

11. If agency is not operated by the owner, provide the name(s), address(es) and title(s) of director(s) or officer(s) of the provider agency.

_____
_____

_____
_____

12. Name, address and title of individual, corporation, agency or organization responsible for management of the facility, if facility is not operated by the owner.

_____
_____

13. STATEMENT OF FINANCIAL SOLVENCY

In accordance with 42 CFR 489.12 and for the purpose of establishing eligibility for payment under Title XIX of the Social Security Act, (name of agency) _____, (Federal tax ID #) _____ hereinafter referred to as the provider of services, hereby states and declares:

1. That the provider of services has not been adjudged insolvent or bankrupt in a State or Federal Court.

2. That a court proceeding to make a judgement of Bankruptcy or insolvency with respect to the provider of services is not pending in a State or Federal Court.

In addition, the provider of services agrees to inform the Department of Medical Assistance Services immediately if court proceedings to make a judgement of insolvency or bankruptcy is instituted with respect to the provider of services.

14. COMPARABLE SERVICES STATEMENT

_____(name of agency), applying to provide Medicaid Waiver Case Management services, understands that in order to comply with Federal Regulation 42 CFR 447.35, it will not charge the Virginia Department of Medical Assistance Services a higher rate for Case Management Services than is charged the private sector for the same services.

Name of Agency

C. SERVICES AND STAFFING

15. Place a "1" in the block for each service provided by AGENCY STAFF. If services are provided UNDER ARRANGEMENT with another agency or individual, place a "2" in the block, and list the name and address for those agency or individuals.

1. |__| Case Management _____
2. |__| Physical Therapy _____
3. |__| Occupational Therapy _____
4. |__| Speech Therapy _____
5. |__| Social Services/Family Counseling _____
6. |__| Home Health Aide/Homemaker/Personal Care _____
7. |__| Program Aide _____
8. |__| Transportation _____
9. |__| Nutritional Guidance _____
10. |__| Pharmaceutical Service _____
11. |__| Appliances and Equipment Service _____
12. |__| Nursing Care _____
13. |__| Recreational Therapy _____
14. |__| Other (Specify) _____

16. Number of employees on agency staff as full (F) or part-time (P), including employees by contractual agreement. (Place number in appropriate block.)

F	P	
		Registered Professional Nurses
		Licensed Practical Nurses
		Home Health/Personal Care Aides
		Personal Care/Program Aides
		Companion Aides
		Social Worker/Human Service Professional
		Physical Therapists
		Occupational Therapists
		Speech Therapists
		Administrative Staff
		All Others

17. What is the ratio of Case Management recipients to Case Management professional staff? _____

18. Identify current Case Management Professional Staff and their qualifications:

_____ _____

_____ _____

_____ _____

Name of Agency

19. Current list of volunteers/employees who will be utilized as contacts for Case Management recipients (an employee/volunteer roster can be attached instead):

_____ _____ _____

_____ _____ _____

_____ _____ _____

20. This agency plans to offer training for volunteers?
___yes ___no
If yes, describe the course content and frequency of planned in-service training to be provided. _____
_____
_____

21. Upon each renewal of the provider agreement (or upon actual notice to the provider, whichever is sooner) disclosure of the identity of any person (not limited to but including any owner, operator, manager and/or employee) associated with the agency who has been convicted of a criminal office (misdemeanor and/or felony) must be made. (42 CFR 455.106). It is the duty of the provider agency to make inquiry and screen individuals at the point of application for employment to comply with this section.

Has anyone associated with the agency (owner, operators, managers or employees) been convicted of a criminal offense?
___yes ___no If yes, explain:

_____

22. The signature below certifies the following:

1. That the chief administrative agent has received and reviewed the Medicaid Personal Care Services Manual prior to completing this application.
2. That the information within this application is accurate, truthful, and complete.
3. That all registered professional nurses employed by the agency to serve in the capacity of supervising personal care aides will have reviewed the manual prior to the initial visit by Personal Care Services Program staff.
4. That the Department of Medical Assistance Services is authorized to make any contacts or inquiries necessary to facilitate completion of the application process.

_____ _____
Signature of Authorized Agent Date

_____
Authorized Agent's Name and Title (typed or printed)